

**Employee Enrollment / Change Form**☐ Initial Group ☐ COBRA ☐ Open Enrollment☐ New Employee ☐ Change (complete change section on reverse side)

Benefits Administered by:

UMR - ENROLLMENT SERVICES

PO BOX 8052 - WAUSAU, WI 54402-8052

EMPLOYER NAME City of Waukesha	GROUP NUMBER 76-412069	EMPLOYEE HIRE DATE	COVERAGE EFFECTIVE DATE
EMPLOYEE LOCATION: <input type="checkbox"/> 001-Clerical <input type="checkbox"/> 002-Fire <input type="checkbox"/> 003-Police <input type="checkbox"/> 004-Streets <input type="checkbox"/> 005-Clean Water Treatment	<input type="checkbox"/> 006-Building Inspectors <input type="checkbox"/> 007-Management <input type="checkbox"/> 008-Park & Recreation <input type="checkbox"/> 009- Library Mgmt <input type="checkbox"/> 010- Library <input type="checkbox"/> 011-Cemetery	<input type="checkbox"/> 013-Elected <input type="checkbox"/> 014-Engineers and Techs <input type="checkbox"/> 020-Dispatchers <input type="checkbox"/> 017-Retirees <input type="checkbox"/> 716-COBRA	

SOCIAL SECURITY NUMBER		HOURS WORKED WEEKLY	
NAME: LAST	FIRST	M.I.	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH / /	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS	HOME TELEPHONE NUMBER ()

Medical Plan (select one): ☐ PPO 1 Low Copay ☐ PPO 1 High Copay ☐ PPO 2Coverage level (select one): ☐ Employee ☐ FamilyDo you or any family member currently have other health coverage? ☐ Yes, single ☐ Yes, family ☐ No

If yes to the above question, complete the following:

Person's name _____ Employer Name _____

Carrier Name _____ Plan Number _____

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

LAST	FIRST	MI	SS# (Required)	BIRTH DATE	GENDER	RELATIONSHIP TO EMPLOYEE
Spouse Name					<input type="checkbox"/> M <input type="checkbox"/> F	
Child(ren) Name					<input type="checkbox"/> M <input type="checkbox"/> F	
1.					<input type="checkbox"/> M <input type="checkbox"/> F	
2.					<input type="checkbox"/> M <input type="checkbox"/> F	
3.					<input type="checkbox"/> M <input type="checkbox"/> F	
4.					<input type="checkbox"/> M <input type="checkbox"/> F	
5.					<input type="checkbox"/> M <input type="checkbox"/> F	

COMPLETE THIS SECTION IF MAKING CHANGES.

Effective date of change: _____ Please specify change and update in appropriate section.

- ☐ Employee name change
☐ Employee address change
☐ Job location change
☐ Return to work
☐ Other coverage change
☐ Date of Marriage _____
☐ Date of Divorce _____
☐ Other _____
☐ Eligible for Medicaid/CHIP subsidy
☐ Loss of Eligibility for Medicaid/CHIP subsidy
☐ Add dependents
☐ Remove dependents (list names) _____ Reason: _____
☐ Add coverage
☐ Voluntarily Terminate coverage (Indicate which coverage) _____
☐ State/Federal Continuation
Employee Signature Required _____
☐ Employment termination:
Reason: _____ Last day worked _____ Date coverage terminated _____

WAIVING COVERAGE

Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:

- ☐ I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. For specific plan language contact your Human Resources Representative.

CERTIFICATION: I freely and voluntarily waive all coverage noted above.

EMPLOYEE SIGNATURE

DATE

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

- ☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

EMPLOYEE SIGNATURE

DATE

EMPLOYEE: RETAIN THIS PAGE FOR YOUR RECORDS

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact **UMR** at:

2700 Midwest Drive
Onalaska, WI 54650
800-236-8672

Green Bay Regional
Office
800-236-2515

Rockford Regional
Office
800-783-9281

Lexington Regional
Office
888-997-7716

Women's Health and Cancer Rights Act Notice

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you with this enrollment notice outlining the coverage that this law requires our plan to provide.

Our group health plan has always provided coverage for medically necessary mastectomies. This coverage includes procedures to reconstruct the breast on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance with the breast on which the mastectomy is performed.

The following benefits are required to be provided if benefits are provided for a mastectomy:

1. Coverage for reconstruction of the breast on which the mastectomy is performed.
2. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
3. Coverage for prostheses and physical complications resulting from any state of the mastectomy, including lymphedemas.

These benefits are subject to the same deductible, copays and coinsurance that apply to mastectomy benefits under the plan.

Notice of Children's Health Insurance Program Reauthorization Act (CHIPRA)

If *you* and/or *your dependents* were covered under a Medicaid plan or State child health plan and *your* coverage is now being terminated due to a loss of eligibility; or if you are determined to be newly eligible for premium assistance through Medicaid, this will be considered a special enrollment event. You must request coverage within 60 days after the date of termination of such coverage or determination for premium assistance.